Flexible Spending Accounts Enrollment and Status Change Form

Please print clearly. Return your completed form to your employer.

Employer/Company Name: Division:

Last Name: First Name: SSN#:

Address: Phone: ( )

City: State: Zip: Email:

FOR H.R. USE ONLY: Effective Date: _____ Status Change Date: _____

Termination Date: _____ No. of Pay Periods: _____

Premium Only Plan—I understand that any premiums I am obligated to pay for health care coverage for myself and my eligible dependents, will be deducted from my pay on a pretax basis unless I otherwise direct.

ANNUAL ENROLLMENT ELECTION ¾ Indicate plan(s) selection below:

HEALTH CARE FSA (please check one) refer to your employer's enrollment materials for your Plan's Annual Maximum	**DEPENDENT CARE FSA (please check one)** $5,000 Annual Maximum (or $2,500 if married filing separately)
❑ I wish to redirect $_____ for the upcoming plan year. ($_____ per pay period) to my Health Care FSA. Maximum deduction amount for calendar year is $3000.00.	❑ I wish to redirect $_____ for the upcoming plan year. ($_____ per pay period) to my Dependent Care FSA. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.
❑ I **do not** wish to redirect any money for eligible health care expenses.	❑ I **do not** wish to redirect any money for eligible dependent care expenses.

STATUS CHANGE ¾ Complete the following and indicate the reason for the Change in Status:

❑ Change in employee's legal marital status—including marriage, divorce, spouse's death, legal separation, and annulment.	❑ Change in work schedule— reduction or increase in hours by employee, spouse, or dependent
❑ Change in the number of tax dependents—including birth, adoption, placement for adoption, or death.	❑ Change in residence or worksite of employee, spouse, or dependent.
❑ Termination or commencement of employment by employee, spouse, or dependent.	❑ Dependent satisfies (or ceases to satisfy) dependent eligibility requirements—attainment of age, student, status, etc.
❑ Change in dependent care provider or change in provider's cost.	❑ Other. Please explain _____

HEALTH CARE FSA		**DEPENDENT CARE FSA**	
Old Annual Election	**New** Annual Election	Old Annual Election	**New** Annual Election
$_____	$_____	$_____	$_____
Old Per Pay Amount	**New** Per Pay Amount	Old Per Pay Amount	**New** Per Pay Amount
$_____	$_____	$_____	$_____

Authorization ¾ Read Carefully

I understand that the choices I have indicated above must remain in effect for the entire calendar year unless I have an eligible change in family status. I authorize the above amounts to be deducted from my pay on a pretax basis. I understand that any unused balances in either the Health or Dependent Care FSAs at the end of the Calendar Year shall be forfeited. I understand that the expenses that I claim for reimbursement must be incurred during the Calendar Year while I am an eligible participant under my employer's Plan and that these expenses have not been reimbursed through any other plan or through any other method or means, nor will I seek reimbursement elsewhere. I understand that I am responsible for the sufficiency, accuracy, and veracity of all information relating to my claims, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. I understand that no tax deduction is permitted for amounts for which reimbursement is made. I agree to comply by the terms of this Plan. **I understand that there is an administrative fee of $6.00 per month to participate in this program and the amount will be deducted on a biweekly basis.**

I understand that if I use the TRI-AD *FlexCard*[sm] for purchases other than Qualified Expenditures or fail to provide proper documentation for my purchases, as determined by the Plan Administrator, the IRS or any other party having authority, that I have violated this Agreement and my obligations under my employer's Plan. I authorize my employer to collect from me personally or withhold such funds from my pay or any other amounts due including any taxes, fines, surcharges or penalties that may be assessed for the use of the *FlexCard*[sm] for Non Qualified Expenditures. I also understand that my Card may be immediately suspended and/or permanently revoked.

_____ _____

Signature of Employee **Date**

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